

**A Cross-Provincial Comparison  
of Health Care Policy Reform in Canada**

**Waiting List Management in Quebec:  
Implementing a System to Manage Access to Care**

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## Introduction

In response to the issue of waiting list management in Quebec, policy-makers decided to implement a computerized service access management system (SGAS) proposed in August 1998 by the Support Group for Access to Specialized Surgical and Medical Care (*le groupe de soutien à l'accès aux services chirurgicaux et médicaux spécialisés*). We will begin by providing an overview of the SGAS, which we will follow with an analysis of how the issue of service access management came to emerge, how it arrived on the government agenda and how a decision on the matter was reached. We will conclude by assessing how the system has evolved and we will evaluate conclusions that can be drawn. Finally, in the appendix, a chronology of events will recapitulate the body of actions taken in this portfolio over time.

### I- What is the SGAS?

The SGAS is a computer system with two principal functions: based on clinical data provided, it weighs cases and risk factors and, using this evaluation, ranks patients on a prioritized list. The first system to be implemented took place in the discipline of tertiary cardiology (cardiac surgery, angioplasty and diagnostic catheterization), but it now also extends to radio-oncology...

The ranking of the weight and urgency of cases is based on criteria developed by a consensus of experts who had determined the clinically acceptable wait time for treatment of each pathology. The experts in question were doctors specialized in the pathology in question and approved by the professional organizations and the College of Physicians of Quebec (*Collège des médecins du Québec - CMQ*). The treatment request forms filled out for each patient requiring surgery or medical treatment were developed by specialists and approved by advisory committees, the professional organizations, the CMQ and the Committee for Standardization of Forms of the Ministry of Health and Social Services (MHSS - *le Comité de normalisation des formulaires du MSSS*). As a result, the codes of best clinical practices are approved for the entire province of Quebec, facilitating uniform treatment throughout the province regardless of where treatment takes place (Public Information Office of the MHSS (*Direction*

*des communications du MSSS*), Autumn 2001, p. 1). Access to this database is limited to health professionals<sup>1</sup>.

The SGAS system, originally designed to include all waiting lists and to be administered centrally, functions at present as a management system for hospitals and a tracking system for the Ministry of Health. While use of SGAS is not strictly necessary, the program has been installed in all hospital institutions where tertiary cardiology and/or radio-oncology surgery is performed.

### **1. What are the advantages of the SGAS?**

Thanks to access to the computer database, hospital workers can garner exact knowledge of the number of patients waiting for treatment, the severity of each case and the average wait time for a given treatment. The system therefore allows a hospital to prioritize cases according to predetermined factors. It also identifies the number of patients who are not treated within delays defined as clinically acceptable.

An advantage of SGAS for patients is that it provides patients with the confidence that they are receiving fair treatment with respect to the delay in access to care.

As far as hospital institutions are concerned, the system allows for greater transparency and equity in the management of priority of access to treatment. Furthermore, hospitals are in a position to better manage the flow of patients, permitting better engineering of the availability of operating rooms and treatment rooms. Because the system makes it possible to compile relevant statistics, hospitals can also assess their capacity to respond to the demand for services. Lastly, the data can be used to justify improvement projects or other strategies designed to offer the required services. (*Public Information Office of the MHSS (Direction des communications du MSSS)*, Autumn 2001, p. 3).

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<sup>1</sup> Apart from the data compiled by SGAS, the MHSS also publishes online the state of waiting lists for sectors other than cardiac surgery and radio-oncology. Statistics for these sectors originate with the MHSS, which compiles the statistics manually from the data sent to the ministry monthly by the regional agencies. Statistics on tertiary cardiology and radio-oncology are generated and recorded in the SGAS system.

With respect to various health care agencies and the MHSS, the SGAS facilitates the compilation of statistical data for clinical or epidemiological purposes or for purposes of quality assessment.

“To benefit from real-time information on the number of patients waiting for treatment or services, the proportion of patients for whom waiting times exceed clinically acceptable delays and the capacity of hospitals to respond to the demand.” (Public Information Office of the MHSS (*Direction des communications du MSSS*), Autumn 2001, p. 3).

## 2. A few examples of target wait times<sup>2</sup>

- Heart surgery: 3 months
- Diagnostic Catheterization: 2 months
- Angioplasty: 2 months
- Radio-oncology: between 0 and 8 weeks
- Cataract surgery: 6 months
- Hip replacement: 3 months
- Knee replacement: 3 months
- Other day surgery: generally 6 months
- Other surgery requiring a hospital stay: generally 6 months (MHSS, 2005)

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<sup>2</sup> *Ministère de la santé et des services sociaux. Les listes d'attente : Questions fréquentes.*  
<http://www.msss.gouv.qc.ca/sujets/listesdattente/>, March 18, 2005.

*Direction des communications du Ministère de la santé et des services sociaux.* Autumn 2001. Bulletin SGAS. Québec : Gouvernement du Québec, 3 p.

## **II- The Government Agenda (1992-1994)**

The issue of waiting lists made its appearance around 1992 and was publicized in large part by the media. Ensuing public pressure forced the government to adopt a position.

### **A- The context**

The reform of health care services implemented by Health Minister Rochon in the 1990's exacerbated problems of access to care, which in turn created waiting lists. The elements that underpinned this rationalization were the rationalization of resources, the shift towards ambulatory care, and massive retirement programs.

#### **1. The rationalization of resources and the shift towards ambulatory care**

The difficult financial context of the period, marked by huge cutbacks to the health sector with the goal of achieving a balanced budget (a zero deficit), put enormous pressure on the system. In the context of budget cutbacks, operating units that drained significant financial resources were the first to be affected. The impact was worsened by the fact that budget cuts were made by applying a percentage of the cuts to each sector, without regard to the relative importance of the sector in question. For that reason, the effect of the rationalization of resources on the budgets of operating units was weighty and caused a significant reduction of the services delivered as well as an increase in waiting lists.

In addition, the Rochon reforms had put into motion the shift towards ambulatory care, a program designed to cut down on hospital stays and more appropriately tailor the response of the health care system to certain health problems. The initiative resulted in the closure of a number of hospitals, creating significant pressure on those that remained.

#### **2. The early retirement program**

In parallel to ongoing restructuration, an early retirement program for health professionals was proposed in order to reduce the wage bill. The massive early retirement of paramedical as well as medical professionals reached proportions that had not been foreseen and were not, in fact, desirable. As a result, within a matter of months, the health care network

was deprived of its most experienced professionals, those who also had the best knowledge of the health care system. This phenomenon contributed directly to the increase in wait times.

### **3. The consequences**

#### **a) Managing the waiting lists became a means of managing the health care system**

With a view towards capping expenses, hospitals tended to restrict access to the technical wherewithal for expensive surgery. Furthermore, in order to spare the use of personnel, the frequency of operations was decreased, reinforcing the creation of waiting lists. In this way, the management of resources both human and material had direct consequences on the capacity of the system to care for the ill. The waiting list thus became a means of managing expenses in the public system. Between 1995 and 1998 and up to 2003, the number of operations in Quebec had begun to drop, explaining in part the growth of waiting lists.

#### **b) The transfer of patients**

Notwithstanding the above, cuts to emergency services had been less drastic than cuts to other sectors, in order to protect patients' ability to access the system. Patients were increasingly directed to emergency rooms as a means to gain access to services, contributing to the swelling of waiting lists at emergency.

#### **c) Hospital deficits**

Subsequent to the reforms, hospitals began falling into debt, prompting the implementation of the law on balanced budgets in 2000. Because hospitals are the last resort in the health care safety net, however, they could not stop providing services in order to keep their budgets in balance.

### **B- Media communication**

In 1992-1994, health professionals used the media to transmit information on the situation of waiting lists and access to care in hospitals. Two principal groundswells of media coverage roused public opinion and publicized the issue of access and waiting lists, particularly for general surgery and heart surgery.

#### **1. Problems encountered in the specialty of general surgery**

General surgeons were the first to raise the issue, especially by means of their professional association (The Quebec Surgical Association - *l'Association des chirurgiens généraux du Québec*, now the *Association*

*Québécoise de Chirurgie*). The surgeons used the media to inform the public about the state of waiting lists for general surgery. They claimed that in Quebec, 40 000 individuals were waiting for surgery.

In response to this first groundswell of media pressure, the government created a working group in 1993: The Committee for General and Orthopedic Surgery in Quebec (*le Comité sur la chirurgie générale et orthopédique au Québec*).

## **2. Problems encountered in the specialty of heart surgery**

Following these developments, a second groundswell of pressure took place in 1993, with a view to revealing problems of access to ultra-specialized surgery. In contrast to the media coverage of general surgery where the issue was explored in general terms, the press now reported on individual cases of patients awaiting treatment or who had died while awaiting heart surgery. Once again, in order to address this pressure, the government introduced, in 1994, a specific working group on the issue of access to tertiary cardiological care: The Committee for Wait List Management in Tertiary Cardiology (*le Comité sur la gestion des listes d'attente en cardiologie tertiaire*).

During this period, the government learned two things. For one thing, it learned that it did not dispose of reliable tools that would allow it to evaluate the magnitude of the problem. For another thing, in order to truly take stock of the problem, it would be necessary to study a given situation in its entirety and not limit itself to selected elements of the problem. For example, with respect to tertiary cardiology, it would be necessary to consider not only surgery itself but also the clinical investigation and the diagnosis.

### III- The Decision-Making Agenda (1995-1997)

Following the recommendations published in 1993 by the Committee for General and Orthopedic Surgery, the problem of waiting lists remained unchanged. It would be necessary to await 1995 in order for waiting lists to arrive on the government agenda and Minister Rochon to initiate the Action Plan for Access to Surgical Care (*Plan d'action sur l'accessibilité des services en chirurgie*) and the Support Group for Access to Surgical Care (*Groupe de soutien à l'accès aux services chirurgicaux*). In the meantime, the recommendations of the Committee for Wait List Management in Tertiary Cardiology allowed the government to make targeted spending immediately after the filing of the report because it now disposed of an overall picture of the situation for that specialization.

During this period, media pressure continued, publicizing numerous individual cases of waiting list patients.

#### A. The Action Plan for Access to Surgical Care

##### 1. The context

The Action Plan took place in a context where the health care system of Quebec was in full transition. The Plan hoped to not only keep costs in check but also better address citizens' needs. The Plan summarized the situation thus:

"The system is in transition: the transformation of the network could make it possible to adapt it to citizens' needs and improve its capacity to offer quality services, achieving more cost-efficient results."

Also: "The raison d'être of the system remains unchanged: "to maintain and improve the health and well-being of the population of Quebec, within the scope of available resources"." (p. 1).

The shift towards ambulatory care program implemented by Minister Rochon put special emphasis on new means of treatment such as day surgery and the consolidation of primary care with the family physician as an entry point into the system:

"We need to develop appropriate measures: replacing hospitalization with day surgery, avoiding unnecessary hospitalization, and relying more on outpatient services, without compromising quality of care." (p. 2).

## 2. The goals

The principal goal of the plan was to increase access to surgical care. Sub-goals for more specific objectives were as follow:

- Reduce wait times:

Reduce wait times for general surgeries by 50% over the next year.

This objective became the priority for the health care system, for all Regional Boards and all hospitals (p. 4).

- Increase pre-admissions:

Within 1 year, have 75% of patients with planned surgeries receive presurgical exams and outpatient consultations before being hospitalized; increase the number to 95% within 2 years.

- Increase day surgeries:

Within the next year, have 85% of surgeries performed on the day of admission to the hospital (p.5).

- Reinforce day surgery capacity:

Of procedures identified as suitable for day surgery for eligible patients, 50% to be performed in day surgery within 2 years and 100% to be performed in day surgery within 4 years (9 targeted types of procedures) (p. 6).

## 3. The tools

Two documents were published in order to assist health care professionals with implementing the Action Plan ("Day Surgery and Its Organization" ("*La chirurgie d'un jour et son organisation*") and "A Management Guide for the Operating Room" ("*Guide de gestion du bloc opératoire*"). In addition, the Ministry created the Support Group for Access to Surgical Care (*L'équipe de soutien à l'accès aux services chirurgicaux*) (MSSS, 1995).

### B. The Support Group for Access to Surgical Care

This support group was created at the Ministry of Health and Social Services in order to assist professionals meet the goals of the Action Plan.

#### 1. How the group worked

The procedure was similar to the one adopted at the time by the Tactical Intervention Group for Emergency Units (*Le Groupe tactique d'intervention sur les urgencies*). The group was brought in for all types of surgery except tertiary cardiology and cardiac surgery, as the Committee for Wait List

Management in Tertiary Cardiology was already studying these specialties (*Comité sur la gestion des listes d'attente en cardiologie tertiaire*).

The group conducted visits of operating rooms. Together with experts in each specialization and sub-specialization, it evaluated the workings of the operating team in an attempt to identify problems and difficulties. It then produced a report on its findings and met with the various participants concerned within the hospital. An evaluation of the activities of the group, however, revealed that in fact it conducted very few operations of this nature.

## 2. Problems encountered

Indeed, instructions given by the authorities of the MHSS stipulated that the Support Group only undertake internal investigations at the request of hospitals or the Regional Boards. This approach was justified by the fact that the ministry wished to respect the respective mandates of hospitals and Regional Boards (in order to not ruffle feathers...). This situation, however, limited the group's potential for participation.

It is also noteworthy that the group disposed of no financial means of provoking, inciting, or forcing change within institutions, in contrast to the Tactical Intervention Group for Emergency Units (implemented at about the same time at the Support Group). The principal mandate of the Support Group was to develop a tool to compile summary data on waiting lists, but it had neither the mandate nor the resources to develop a computerized management program.

## 3. Conclusions

### 3.1 Organizational problems

Over and above the lack of financial and material resources, many problems were attributed to the organization, the operation and the leadership exercised within operation rooms. The work was largely performed behind closed doors. The world of surgeons and operating rooms is an exclusive environment with little transparency. Some operations were controlled by certain groups of individuals or certain interests. It became apparent strong resistance to change was in play, and that institutions themselves were reticent to change. The lack of resolve by institutions to implement the recommendations of the Support Group was in large part due to pressure

groups that did not wish to modify their habits and structures. The Group was thus made to understand that notwithstanding any scientific rationale, the reality on the ground must also always be considered as part of an attempt to provoke change.

### 3.2 Poor computerization

The Group remarked at what point operating units were poorly computerized. The most basic information was simply not available. At the time, the digital management system OPERA was coming online, but it required considerable investment on the part of institutions, which were also struggling with significant budget cuts. For that reason, few institutions chose to invest in the technology.

#### **IV- The Choice of a Policy (1998 - the present)**

This period of the policy-making process can be sub-grouped in three sub-periods. The first consists of the emergence of the idea of management of access to care, the second deals with the implementation of the system to manage access to care and the third comprises the sequels to these developments.

##### **FIRST SUB-PERIOD:**

##### **1998-1999 - EMERGENCE OF THE IDEA OF MANAGEMENT OF ACCESS TO CARE**

The notion of access management began to sprout in 1998, more specifically in the month of August. At this juncture, the Support Group for Access to Specialized Surgical and Medical Care proposed the implementation of a system based on active management of access to care, rather than a passive compilation of waiting lists on given dates. Jean Rochon supported the idea and gave the Group the mandate to produce a system of management of access to care. This marked the beginnings of SGAS. Jean Rochon was all the more taken with the idea, given that the effects of the shift towards ambulatory care were starting to make themselves felt and that the problem of waiting lists was amplifying.

These overtures were followed by a period of transition with the advent of Pauline Marois, the new Minister of Health and Social Services. In September 1999, Pauline Marois abolished the Support Group for Access to Specialized Surgical and Medical Care. The mandate to continue with the creation of a system of management of access to care was entrusted to the Department of Excellence of Personnel and Medical Services (*la Direction de l'excellence de la main d'œuvre et des services médicaux*) of the MHSS.

##### **1. Why the idea of access management?**

As of 1995, information on waiting lists began to be gathered on an irregular basis, 3 to 4 times per year. The data facilitated the analysis of trends over time but the time lag between the point at which the data were current, and the point at which the compiled data were available for analysis, meant that it was impossible for administrators to address problems in a timely manner.

In 1998, limits to the quality and reliability of the data compiled began to be apparent. There were enormous disparities in data collection between institutions, resulting from the fact that institutions were not obliged to follow given procedures in the data collection process. As it stood, the system could generate an overview of the waiting list situation, but users lacked the information and tools necessary to actively manage the lists. The search was on for a means of comparing institutions to each other, in order to act rather than react.

This development marked the first glimmers of the idea of "access management". Rather than compile for the sake of compiling, it would be necessary to develop systems and tools to assist in the management and prioritization of patients in real time if at all possible.

## 2. The case of Montreal

### 2.1 The context

The Regional Board for Health and Social Services of Montreal (RRSSS) had, on its own initiative, undertaken work on the issue of a selection of waiting lists (heart surgery, orthopedics (hip and knee), and cataract surgery) as of 1998. The special council of the director of the Board had seen on the NHS website a certain number of questions and answers respecting waiting lists. The NHS had targeted certain operations (hip, knee, cataracts), which were considered "relevant" because clinically effective. These referred to proven methods that were considered effective in the international scientific literature.

Armed with this information, the Regional Board decided to analyze its own data and add management of waiting lists to its strategic plan in the spring of 1998, in order that the idea be taken up in the electoral platforms of the two political parties before the fall elections.

As of 1999, improvement of wait times for the surgeries selected by the Regional Board of Montreal was part of the financial priorities of the new government.

### 2.2 The system

The idea was to have a functional waiting list management system in all hospital centres, preliminary to the implementation of a regional-level

monitoring system. Accordingly the Regional Board put together a monitoring and management system of waiting lists for heart surgery on the computer system of the health network, using Lotus Notes.

### 2.3 The results

The system was abandoned given the announcement by the MHSS of the deployment of SGAS. Rather than mandate the Regional Board of Montreal, which had already acquired some experience in the domain, to develop the SGAS project, the MHSS awarded the contract to the Regional Board of the Bas St-Laurent, despite the fact that the institutions of this Board did not perform heart surgery. The Regional Board of Montreal thus found itself without a waiting list management system for some time.

#### SECOND SUB-PERIOD:

#### 1999-2003 - IMPLEMENTATION OF THE SYSTEM TO MANAGE ACCESS TO CARE (SGAS)

##### 1. The first SGAS project - all lists (1999-2001)

The goal in 1998 was to provide all surgical disciplines that had waiting lists, with an access management system. Implementation was to be timely and significant in scope (all specializations).

##### 1.1 The goals and characteristics of the system

###### a) Manage waiting lists by means of a standardized provincial tool.

The objectives of the tool were multifold and were expected to:

- Guarantee access to care within clinically acceptable wait times
- Allow participants to reach consensus on what is deemed a waiting list<sup>3</sup>

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<sup>3</sup> One of the most important problems identified at this time was the fact that the actors implicated in the debate did not agree on the definition of a waiting list patient. The confusion centred on wait times: when was a patient considered to be waiting for treatment to become available, as opposed to simply experiencing a normal and reasonable delay before receiving care?

- Develop similar criteria for all surgeries for which there were waiting lists<sup>4</sup>
- Rapidly identify patients whose wait times for treatment had exceeded acceptable periods, taking into account that being on a waiting list was not harmful in itself as long as the operation took place within the acceptable delay.
- Improve management of surgery priorities. Until then, the priority for surgeries had been determined by surgeons: SGAS was designed to relieve surgeons of this task, by taking into account pre-established criteria for the ranking of cases and by establishing a schedule for operations that would maximize the number of cases treated within the available time.
- Make the circulation of patients more efficient by allowing referring physicians to better choose the hospital to which to refer their patients, by means of comparing waiting lists between institutions.

b) Collect clear and reliable data

Because the data compiled lacked timeliness and reliability, the MHSS did not have the means to counter the assertions made by interest groups and the media. It was becoming urgent that the ministry dispose of clear and reliable data, in order to respond to public criticism.

Standardization in the compilation of the data would make it possible to evaluate waiting list management performance as well as quality of care, and to compare the results between hospital institutions. The system would also allow for the dissemination of comparative information towards hospitals, a departure from the present state of affairs, where there existed only a one-way flow of data from the hospitals towards the ministry, with no information going back to the hospitals in return. It was hoped that the data could, in fact, be shared. The system would also reveal whether investments made to increase the number of surgeries performed, had been successful.

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<sup>4</sup> Basic deliberations took place in order to determine what constituted reasonable delays in access to treatment.

## 1.2 Sources of inspiration

Sources of inspiration were multiple. To begin with the Canadian context, the experience of Ontario's Cardiac Care Network was a primary source of inspiration. Saskatchewan's provincial registry as well as the Western Canada Wait List also influenced the Quebec model, as did the experiences of some local institutions that had experimented in waiting list management and data collection. The remainder of the sources of inspiration came from the international literature on waiting list management and the NHS in particular.

2. The SGAS project reorganized - tertiary cardiology (2001-2003)  
In March 2000, Pauline Marois decided to reorganize the SGAS project. Rather than develop a management system for the entirety of services for which waiting lists were in existence, the minister announced her decision to prioritize the development of a system for tertiary cardiology and radio-oncology.

Why the decision to reorganize the project and prioritize tertiary cardiology? Several factors motivated the choice to begin with an access management system limited to access to tertiary cardiological care:

To begin with, certain difficulties were anticipated. During the development of the first SGAS project, it had become apparent that a certain number of problems had arisen from the decision to undertake the totality of waiting lists at the same time. It was difficult to unite all medical specializations at the same time, and to come to an agreement on a common prioritization grid, given the different means of care for different pathologies and the variability in customary practices between physicians. Furthermore, physicians were in general resistant to the introduction of codes of best practice. Rather than risk delays or even see the project aborted because of this resistance, project developers concluded that the only way to accomplish their goals would be to work in small segments, specialization by specialization.

It was equally important, given the large sums in play, for the government to test the workability of the system on a small scale. This was an additional reason for which the government supported the proposal to conduct an experiment before applying the system to all specializations. Such an

experiment could, furthermore, impart important lessons for the implementation of the system in other specializations.

The state of the waiting lists in heart surgery and the unique nature of this specialization made this discipline an attractive choice. On one hand, heart surgery patients and radio-oncology patients constituted the most dramatic examples of waiting list subjects; on the other hand, the waiting list in tertiary cardiology is a list of homogenous patients (only one kind of patient) all awaiting the same kind of surgery, which facilitates case management. Tertiary cardiology is also a wise choice to iron out difficulties in a management system because it is a relatively confined discipline with a limited number of participants and locations of practice; surgeons in the specialty know each other well and work well together.

In addition, media pressure and the professional organizations continued to make themselves felt by exploiting the dramatic and emotional aspects of the issue. The Quebec Network for Tertiary Cardiology (*Réseau québécois de cardiologie tertiaire - RQCT*) had just been implemented. The network, which included physicians, was expected to conduct analyses of waiting lists, the evolution of diseases and other subjects, in order to submit recommendations for the deployment of surgical technology: a mandate that could only be accomplished if the group disposed of valid, reliable and timely data. The SGAS would be in a position to provide this data.

Finally, from a financial point of view, the MHSS lacked the human and financial resources to implement a system to manage the lists for all specializations. The difficulties experienced by the ministry up to that point had pointed up the limits of its budget for the development of the computer program.

As a result of the above, the original plan to acquire tools for the management of waiting lists accumulated significant delay. Between 1995 and 1998, the MHSS put pressure on institutions to acquire the OPERA software program. Implementation of the new SGAS system in tertiary cardiology was scheduled to begin in 1998, with implementation for other types of surgeries to follow. Because the situation was supposed to be temporary, investments for other waiting lists had been shelved. The application of a computerized tool was thus put off from one year to the

next. In the interim, institutions had stopped equipping themselves with computerized management tools.

As a result, then, of promises that had not been kept, waiting lists for disciplines other than tertiary cardiology were left without any kind of management system.

A number of obstacles and challenges marked the development and implementation of SGAS, most particularly because of internal problems at the MHSS and obstacles that came up during negotiations with the doctors and the institutions in play.

With respect to the internal problems at the MHSS, a lack of commitment and of continuity had resulted in organizational problems at the ministry. For example, waiting lists in tertiary cardiology might be one responsibility, the lists in radio-oncology a second and computerization a third. In addition, SOGIQUE, the private firm in charge of developing the computer program, had its own role to play. This dissipation of responsibilities put the very viability of the project at risk. The succession of directors and of ministers was additional obstacles to the continuity of the project as some actors were less convinced of the merit of deploying the SGAS system. The differing management styles of the participants further hampered progress. For example, the instinctive political reaction of Jean Rochon was to obfuscate information on waiting lists, while Pauline Marois was more open to disseminating information. It was therefore necessary that the MHSS continually readapt to different styles. The organizational culture of the ministry thus played an important role in the evolution of the dossier.

Another striking aspect of the management of this portfolio was the absence of anyone to carry the project at the political level. Indeed, no individual surfaced as able to carry the project at the strategic level within the MHSS. No single person concerned had enough influence with deputy ministers and the minister him/herself to ensure the timely progress of the portfolio. From the beginning, SGAS was seen as a technical dossier only relevant to specialists. The lack of leadership and strategic vision, then, led to an absence of economic forecasting, jeopardizing the development of the system for other types of surgeries.

For these reasons, it can be said that the situation was such that it was difficult to draw the attention of policy-makers and higher-level civil servants to the issue of the financing and deployment of SGAS.

This lack of attention had an adverse effect on the budgets, materials and human resources associated with the project: few staff were assigned to the dossier, budgets for the project were cut and took a long time to be distributed after the SGAS project was approved. The annual nature of the vote on budgets put the project in a situation of short-term risk, complicating the organization of human and financial resources: energy was concentrated on this insecurity and not on the deployment of SGAS. In addition, the company in charge of implementing the project (SOGIQUE) experienced serious setbacks: its very survival had been called into question.

With respect to the challenges in negotiations with the institutions and the professionals, certain institutions and professionals feared losing a negotiating tool. For professionals and medical federations, waiting lists were a political weapon used in negotiating with the government for various concessions relative to medical practice. It was therefore an advantage to not have precise information on the state of waiting lists (how many patients on the lists, in which hospitals, for which surgeries?) since this gave negotiators a certain freedom to manipulate discussions using data based on speculation. With an access management system, it was now possible to have a precise idea of a given waiting list at a given point in time. The interest groups and the politicians would be obliged to show their hand.

Notwithstanding the above, some actors came to see that SGAS could also be an internal negotiating tool insofar as it would allow a certain degree of independence in management within a department, in addition to identifying those sectors which most required investment.

The position of physicians on the issue was ambiguous. In some ways, physicians saw the fact of having a waiting list as the price of their success. Furthermore, in the allocation of time in the operating room, hospitals favoured doctors whose waiting lists were long. It is also necessary to recall that the medical profession has historically shown reluctance to submit to outside supervision. For that reason, doctors were slow to welcome a system that would allow administrators to monitor their activities and their

management of waiting lists (treatment quality control, monitoring of the priority for surgeries - the system itself decided on the priority for surgery). They found it difficult to accept the idea of SGAS as a tool in the service of medical practice...

In the end, in order to bring the doctors on board, the MHSS decided to finance the purchase of technology for doctors who would agree to participate in the project. After this move, the next challenge was to bring everyone together to discuss the next step. It took enormous amounts of time and energy to succeed in uniting heart surgeons, the cardiologists of Quebec and Montreal and the referring cardiologists of other regions in order that they reach an agreement on clinically acceptable wait times, the content of the SGAS tool and how to coordinate case treatment. Consensus was extremely difficult to reach.

With respect to the day-to-day management of SGAS, doctors did not wish to personally take on data collection for the system, as this would increase their workload. The SGAS system, however, is based on the progressive compilation of data by all individuals participating in the treatment of a patient awaiting surgery. Paradoxically, even if doctors resisted personal participation in the data collection process, they also opposed the idea of incremental compilation. Because SGAS was designed to permit the evaluation of the quality of treatment and services, doctors did not wish to relinquish control of data collection out of fear that this might compromise the reliability of the data in question.

In closing, it is clear that the development and implementation of SGAS was the fruit of the labours of a small number of actors. The project was managed behind closed doors at the MHSS. A resume of the actors involved reads as follows:

- At the MHSS: 3 people, the deputy ministers and the minister;
- SOGIQUE;
- Private companies;
- The Management Committee of the SGAS;
- Users' committees in the institutions where SGAS was in use;
- Doctors and surgeons;
- Medical federations and the College of Physicians;
- Regional Boards;

- The Quebec Hospital Association;
- Participating institutions;
- Nurses.

### 3. The SGAS project in radio-oncology

#### 3.1 The transfer of patients to the United States (1999)

Certain forecasting and planning had taken place during the administrations of Ministers Lavoie-Roux, Robillard and Côté. At that time, staffing shortages and shortages of devices in radio-oncology were anticipated. Succeeding ministers, however, turned a deaf ear to these recommendations.

In 1999, the shortage of personnel and technological devices became flagrant. It was a time when human resource planning had not yet been initiated at the ministry. Pauline Marois was then Minister of the MHSS; she had always been very sensitive to public opinion. She was determined to find a solution to the shortages and followed the situation closely.

The first reaction of the ministry to the urgent shortage of resources and to the growth of waiting lists was to transfer patients to Quebec hospitals where waiting lists in radio-oncology were less daunting. This solution, however, was short-lived, as shortages were widespread throughout the province and the hospitals were already at capacity, if not overloaded with patients. At this time, Ontario and British Columbia were already transferring patients to the United States for treatment. Quebec decided to follow suit.

#### 3.2 The context in which SGAS was implemented

The waiting lists in radio-oncology, like those in tertiary cardiology, were the subject of frequent media reports. Once SGAS was deployed in tertiary cardiology, the MHSS began its implementation in radio-oncology. It took longer to develop and reach a consensus on clinically acceptable wait times for radio-oncology than for tertiary cardiology. While the committee was in session, a class action was filed in the courts. The action held that the acceptable wait time for treatment was 4 weeks after the patient had met with the radiation oncologist. The class action, filed by a consortium of patients, was rejected by the courts. The advising committee, for its part, established that 8 weeks was the acceptable wait time. A decision had been

extremely difficult to reach. For the public, the difference between 4 and 8 weeks was crucial.

### 3.3 How SGAS works in radio-oncology

The SGAS system is somewhat different in radio-oncology than in tertiary cardiology. Because the machinery with which radiation therapy treatments are administered are all equipped with a computerized system for planning patient appointments, SGAS-Radiation-Oncology merely manages the patient list according to the level of priority of each case.

### 4. The other waiting lists

As of 1995, the MHSS introduced a manual system for the collection of data on waiting lists for all other surgeries. Forms were sent to each institution, which in turn transmitted the information to the Regional Boards and then the MHSS. Data was compiled manually every three months. It was then necessary to enter the data by hand into a central file at the MHSS. This means of proceeding did not permit for a reciprocal return of information back to the institutions. Since then, the collection of written information for "other waiting lists" has been improved. It is now done electronically (with Excel) and takes place 13 times a year.

An SGAS-type system is expected to be put in place for "other surgeries" in the future. This is slated to take place after SGAS has been extended to other surgical specializations that are vulnerable to media pressure (orthopedics, cataracts and medical imaging). To develop a system, however, that would allow the amalgamation of all waiting lists, while also taking into account the sum of details unique to each medical specialty, would be logistically impractical. For that reason, the Ministry prefers to err on the side of a more generic system that can be applied to all waiting lists alike (like the Saskatchewan register at the present time).

Difficulties in developing such a system are anticipated, however, because the management process for these other medical disciplines is completely different than it is in the cases of tertiary cardiology and radio-oncology. Waiting lists for other surgeries often include only a few patients in each medical specialty, but together they add up to an important number of individuals in competition for time in the operating room. Furthermore, the surgeons are numerous. For them, it is relatively simple to manage their

respective lists. The problem is to incorporate all of these individual lists into a single system.

5. Other measures (apart from SGAS) taken to address the issue of waiting lists

Other measures were undertaken at the same time as SGAS in order to cut back on waiting times:

- Measures in personnel planning;
- Increase in student cohorts;
- Inter-hospital transfer programs;
- Measures providing for supplementary work hours for some professionals (especially technical specialists);
- The purchase of equipment;
- Measures aiming for the prevention of illness and the promotion of health.

THIRD SUB-PERIOD:

2003-THE PRESENT - SEQUELS OF SGAS

1. The election of 2003

The electoral platform of the Liberal Party brought the problem of waiting lists back to the forefront of public awareness. It was one of the key issues of the party's program. So the election of a Liberal government and the advent of Philippe Couillard began a new period in the dossier of waiting lists.

1.1 The volume of operations

With the advent of Philippe Couillard, certain surgical procedures were targeted for action (cardiovascular care, orthopedic care and ophthalmological care - cataracts in particular). It was hoped to reduce waiting lists in these specialties by performing a greater number of operations. Extra funds were consequently disbursed according to the demand for operations. Targeted procedures were undertaken in order to sporadically address the problem. Accordingly, it became possible to monitor the volume of operations somewhat more precisely, as a consequence of targeted investments. It was at this point that the project to keep the public up-to-date on waiting lists by means of the Internet first appeared.

## 1.2 Waiting lists on the World Wide Web

During the electoral campaign, the Liberals had promised to make waiting lists available on the Internet. The Liberal platform spoke of giving patients the opportunity to choose (that is, to shop for) the hospital where they wished to have their operation performed, on the World Wide Web.

Shopping on the Internet was purely a political invention. The medical federations, the Quebec Hospital Association and certain employees of the MHSS were adamantly opposed to the project: there was near consensus on the fact that it was not a good idea. Why? 1) For the public, it was an invitation to shop around that would create harmful pressure on the medical specialists. For referring physicians, in contrast, it might constitute a benefit, in that it would permit them to better direct their patients. 2) It was also a project that would siphon funds away from the development of SGAS. Accordingly, participants convinced the ministry to abandon the idea. The government saved face by asserting that its original plan for the Internet had been to post information on the state of waiting lists, and nothing more.

The existence on the Internet of this data was effective in silencing criticism. The pressure groups could no longer make headway with their usual arguments because the numbers were now known, even if they were more or less reliable. In truth, the numbers that are available online are neither necessarily reliable, nor are they necessarily comparable. They are not available in real-time (they are 6 months out of date). The only reliable figures come from SGAS and concern tertiary cardiology and radio-oncology.

## V Analysis of the reform process

Analysis of the reform process during the implementation of SGAS testifies to a difficult and chaotic experience. Ideas advanced slowly and the dossier was subject to much experimentation before SGAS was finally put in place. Even after this happened, the SGAS project suffered from a lack of leadership, of continuity, and of funding. We will now proceed to a more precise analysis of the various elements that made the project so complex and difficult to implement.

### 1. Institutional factors

Provincial-level administration is responsible for the management and monitoring of waiting lists. It is true that the federal government can intervene in the matter by means of targeted investments. (LA-02 WLQC): in the case of SGAS, however, decisions were made at the provincial level. The principal institutions involved were the MHSS, the Regional Boards and the various health care institutions. (LA-05 WLQC). At the ministerial level, the entities involved in the project when it was piloted were dispersed in 3 directions, without counting the different ministries involved: these did not necessarily share the same vision for waiting list management (LA-06 WLQC). Furthermore, the SGAS dossier was never seen as a political dossier but as a technical one, and it never benefited from strong leadership at the political level (LA-02 + LA-06 WLQC): the principal leaders of the project were ministry employees. From the start, the Ministry of Health perceived the problem of waiting lists as a technical issue with little political relevance. The ministry had been monopolized by the problem of emergency room care and it therefore applied to the problem of waiting lists, the same method that had been used for the problem of emergency rooms: the creation of a support group for access to surgical care. The group was not, however, provided with the financial means of addressing the crisis. In fact, the very title of the group testifies to the fact that the main issue for the ministry was access and not waiting lists. The Treasury Board had no role in the funding of SGAS (LA-03 WLQC).

Turning to the policies around waiting lists, it is apparent that SGAS is a by-product of the Rochon reforms introduced in the 1990's. In fact, budget restraints (the zero deficit, early retirement programs...) and the shift towards ambulatory care (hospital closures and decreases in the number of

hospital beds) were the two driving forces behind the inflation of waiting lists in Quebec (LA-05 WLQC). As of 1995, strong media pressure publicizing cases of victims of serious illness awaiting treatment, forced the government to face the problem and take action on the issue (LA-05 WLQC).

Prior to *SGAS*, there was no central means of monitoring waiting lists. Because of this, the government lacked a broad-based understanding of the problem and had to submit to the pressure of the press without any means of defence (LA-02 WLQC). As a means of responding to the pressure, the government would sporadically inject funds into the system in an attempt to the problem, but it did so on a reactive level, and not as part of a deliberate plan.

Local-level health care institutions put their own waiting list monitoring systems in place, but these systems were not common to all institutions and were most often "home made" (LA-06 WLQC) if not "hand-made" (LA-05 WLQC). For that reason, it was impossible to compare data between institutions and to have an idea of what was happening at the provincial level (LA-05 WLQC): all the more so, given that the very definition of waiting lists differed from one institutions to the next.

Finally, the recent landmark ruling of the Supreme Court in the "Chaouli" affair testifies to the importance of this issue for Quebec as well as for Canada. Access to care has clearly become a major concern for Canadians, one that will have enormous influence on the evolution of the Canadian health care system.

The press played the principal role in putting the issue on the governmental agenda. Almost every night on the news, reporters profiled the case of a wait-listed person at risk of death as a result of the delay in treatment. The media pounding was nothing less than intense (LA-05 WLQC). In this way, the public used the media as a vehicle to voice its concern and bring about a decrease in waiting times (LA-05 WLQC).

Numerous studies on the problem of waiting lists, written in the form of research and articles, most particularly in countries with state financing, began to appear in the 1970's and grew in number in the 1990's. Most addressed the problem in liberal welfare states (the Beveridge system).

It was only relatively later, in 1998, that a certain consensus was finally reached among decision-makers, professionals and consumer interest groups, with respect to the implementation of a management system for waiting lists. In the background, however, continued to lurk strong reticence on the part of the medical profession and health institutions.

It can be said, then, that the problem of waiting lists was managed principally as a question of technology, and that the hypothesis behind the policy decisions was that the Rochon reforms, particularly decentralization of services and the shift towards ambulatory care, would change the structure of the health care system, thereby fixing the problem of access; a technological tool would give decision-makers a better command of the situation.

## 2. Interest group factors

Patients and the general population put the media very much to use in order to publicize the extent of problems related to the waiting lists (some individuals died not having had access to care, especially surgical care) (LA-06 WLQC).

The publication of the findings of studies on the management of waiting lists in other Canadian provinces also clearly influenced the policy in Quebec (LA-02 + LA-05 WLQC). The principal source of inspiration was the *Cardiac Care Network* of Ontario (LA-03 WLQC). This was followed by the experience of Saskatchewan and the *Western Canada Wait List* (LA-05 WLQC). Certain hospital experiences also helped in the construction of SGAS (LA-06 WLQC). Furthermore, the Regional Board of Montreal foresaw the need to put a management tool for waiting lists in place and had accordingly installed its own system as of 1998. This system was oriented towards the management of waiting lists for heart surgery, hip replacements, knee replacements and cataract surgery, and it allowed administrators to follow the evolution of these lists over time. The system had been inspired in large part by the work of the NHS in the United Kingdom (LA-02 WLQC). It was abandoned, however, once the SGAS project was launched (LA-02 WLQC).

Ever since the beginning of the 1990's, the ministries of health, for their part, had been confronted with the problem of waiting lists; a problem

which, seen from a larger perspective, becomes a question of access to care. Most ministries reacted by "putting out fires" at the cost of millions of dollars, instead of truly seeking to install a policy for waiting list management. The preferred approach, then, was that of short-term solutions (LA-05 WLQC) that took place in a context of health care reform and considerable limitations weighing down the system. The project was, therefore, difficult to carry at a political level, even though administrators at the Ministry of Health were in favour of a tool that would allow them to monitor the problem over time and respond appropriately as a result (LA-05 WLQC).

The problem of waiting lists was included in the political platforms of the Liberal Party and the Parti Québécois in 1998. This concern arose from the recommendations made by the *Committee for General and Orthopedic Surgery (Comité sur la chirurgie générale et orthopédique au Québec)* and the *Committee for Wait List Management in Tertiary Cardiology (Comité sur la gestion des listes d'attente en cardiologie tertiaire)* (LA-05 WLQC). Nonetheless, the minister of health and the minister's cabinet did not prioritize the management of waiting lists and accordingly were very little personally invested in the dossier until around 2001, leaving ministry administrators responsible for the project. It wasn't until the new elections in 2003 that the dossier became more politically active, the Liberals having made it a key issue (LA-01 WLQC). Indeed, as soon as he was instated in 2003, Philippe Couillard injected targeted funds into the system in order to increase the number of surgeries, with immediate results. He had also hoped to allow Quebecers to monitor waiting lists online on the Internet in order that patients and their doctors have the opportunity to "shop" for treatment. This idea, however, was abandoned because of mass opposition on the part of health care professionals (LA-05 WLQC).

Insofar as administrators were concerned, discussion about the need to implement an information system that would facilitate the monitoring of waiting lists was far from new. Administrators were already making use of tools such as human resource planning, increases in student cohorts, and inter-hospital transfers (LA-06 WLQC). From the start, the administrative constituency had been convinced that a system such as SGAS would help them better monitor the problem and facilitate planning as a result (LA-05 + LA-06 WLQC). The director of the SGAS project, however, lacked strong

leadership and had never had a strategic and political vision of the project, restricting himself instead to its technical aspects: communication with the various ministers of health was for that reason at a minimum (LA-01 WLQC). The problem was exacerbated by the dissipation of responsibilities for various aspects of the dossier.

Insofar as professionals and organizations were concerned, the surgeons' organizations (especially in cardiology, orthopedics and general surgery) had been sounding the warning since the beginning of the 1990's (LA-04 + LA-05 WLQC). Even so, after the SGAS system was implemented, not all doctors supported it because of the unremunerated workload it entailed and because they perceived it as threatening to undermine their authority (LA-03 WLQC). For that reason, it was difficult to mobilize doctors to establish a consensus on priority of treatment (LA-03 + LA-05 + LA-06 WLQC). The College of Physicians, in contrast, learned of the phenomenon of wait times by means of visits to hospitals. The organization lent its support to the working groups, helping them establish the priorities in question and putting its moral authority behind the process (LA-04 WLQC); it was not, however, an active participant.

As for Regional Boards, some had developed tools to address the problem and had tried to develop solutions of their own. The board that had made the most progress in this area was the Montreal board. Over all, Regional Boards were in favour of a more centralized system (LA-02 WLQC).

### 3. Ideational factors

The problem of waiting lists arose out of the Rochon reforms and the drastic decrease in the number of hospitals, hospital beds and hospital staff. This problem was, then, principally the creation of a government reform policy (LA-01 WLQC). It was seen, though, as the price to pay for the reform, and not necessarily an issue that would bring the health care system into a state of transition.

Numerous committees studied the problem:

- The Committee for General and Orthopedic Surgery (*Comité sur la chirurgie générale et orthopédique au Québec*) (1993) disclosed the lack of

reliable data, data that would permit a better understanding of the nature of waiting lists and would allow for the quantification of waiting times.

- The Committee for Wait List Management in Tertiary Cardiology (*Comité sur la gestion des listes d'attente en cardiologie tertiaire*) (1994) pointed out that the government did not dispose of reliable tools allowing it to monitor waiting lists.

- The Action Plan for Access to Surgical Care (*Plan d'action sur l'accessibilité des services en chirurgie*) led to the implementation of a team at the Ministry of Health, a team responsible for monitoring the waiting lists and introducing measures to reduce wait times.

- The Support Group for Access to Specialized Surgical and Medical Care (*Groupe de Soutien à l'accès aux services chirurgicaux et médicaux spécialisés*) created and implemented SGAS in order to take a pro-active and not merely passive stance on the issue. At the beginning, SGAS was to be applied to all surgeries, but faced with a lack of funding, it was reoriented to focus only on heart surgery and radio-oncology (LA-05 WLQC).

Finally, the idea that underlay the SGAS measure was the idea that a relevant information mechanism would allow waiting lists to be decreased. This idea was principally upheld by ministry administrators and members of the Regional Boards.

As for the values and opinions expressed throughout the dossier, many surgeons felt that the problem of waiting lists was principally due to a lack of resources and that the allocation of additional resources would improve the situation (LA-04 WLQC). After some prevarication, the government decided that the only effective means of addressing waiting list management was with a transparent system (LA-02 WLQC). With SGAS, the government hoped to increase transparency and fairness in the management of surgical care (LA-01 - LA-04 WLQC). For these reasons, the objectives of the SGAS system were as follows: 1) to have clear and reliable data on the state of waiting lists; 2) to be able to rank patients according to priority, in a fair manner; 3) to determine acceptable limits for wait times; 4) to determine where to allocate budgets; 5) to develop a system that would be transparent

enough to give the public a reasonably accurate notion of how long they could expect to wait (LA-02 + LA-03 + LA-05 WLQC).

#### 4. External factors

Numerous reports, committees, plans, and tools were published, formed and developed during the 1990's on the subject of waiting lists.

- The report of the Committee for General and Orthopedic Surgery (*Comité sur la chirurgie générale et orthopédique au Québec*) (1993)
- *le Rapport du comité de gestion des listes d'attente en cardiologie tertiaire* (1994)
- The Action Plan for Access to Surgical Care (*le Plan d'action sur l'accessibilité des services en chirurgie*) (1995) (Jean Rochon)
- *A Management Guide for the Operating Room (le Guide de gestion du bloc opératoire)* (1995)
- The Support Group for Access to Surgical Care (*L'Équipe de soutien à l'accès aux services chirurgicaux*) (1995)
- *The Classification of Patients Awaiting Heart Surgery (La classification des patients en attente de chirurgie cardiaque)* (1998)
- *The Final Report of the Working Group on Tertiary Cardiology (Le rapport final du Comité de travail de cardiologie tertiaire)* (2000)
- *The SGAS Organization Manual (Le manuel d'organisation du projet SGAS)* (2001)
- The position paper of the College of Physicians (*Collège des médecins*) (2003)

At a political level, several health ministers succeeded each other during the 1990's. An important transition in the management of the dossier took place between the ministries of Jean Rochon and Pauline Marois, who did not share the same vision of the role of the state and the public dissemination of information (LA-05 WLQC). The former was more inclined to delegate responsibility and to keep information confidential, whereas the latter felt it important that the ministry establish its own prerogatives and wished information to be more transparent. In 2003, the change of government and of party, together with the advent of Couillard, a Liberal, relegated the dossier to the back of the line... it is incontestable that the lack of political continuity significantly hampered the long-term vision of the project (LA-06 WLQC).

The economic pressures of the 1990's and the separatist government's commitment to a zero deficit are largely responsible for the appearance of waiting lists in Quebec. The draconian budget cuts made to the health care system and the shift towards ambulatory care were two key factors in the phenomenon. Waiting lists thus became a short-term means of managing the system (LA-02 WLQC).

None of those interviewed and no reports suggested that technological change or the appearance of new diseases might have had an impact on the question.

In contrast, the press played a major if not crucial role in the management of waiting lists by its constant hammering of the same message over a period of years: people were dying from a lack of access to care. The influence of the media forced the government to put the issue on its agenda (LA-05 WLQC).

In closing, research in other provinces had a strong influence on the policy, even though those interviewed did not imply that an access management model was imported from elsewhere (LA-06 WLQC) or that alternative models to the SGAS had been considered.

## Conclusion

SGAS was not the product of a strong consensus at the political, the administrative or the professional level. Administrators at the Ministry of Health were the principal advocates of the program and its legitimacy continues to be called into question today. Nonetheless, the project is still something of a pilot project that is only applied to surgeries in tertiary cardiology and radio-oncology. Despite original ambitions to have it act as a province-wide managing system for all waiting lists, its sphere of operation is restricted to individual hospital institutions.

Nonetheless, few alternatives to replace or modify the system have been proposed. In addition, in order for the system to continue to furnish important information that would allow both tracking and monitoring of waiting lists, major financial investment would be necessary, especially as regards computerization. Such investments are, however, not politically lucrative because of their poor visibility. The paradox in this matter lies in its importance in public opinion versus the little political attention it commands. With the exception of the last few years, the lack of political leadership of the dossier has significantly hampered its continuity over time.

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